CONTRIBUTIONS TO PSYCHIATRY.

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VI.—PSYCHOSES FROM TRAUMATISM.

TRAUMATISM is a very frequently-cited cause of the psychoses, but many of these are cases in which traumatism complicates rather than produces the psychosis. Skae[1] ranges this form and that produced by heat under the same heading, and in a preceding article I have cited his conclusions, and so need scarcely repeat them here. Voisin[2] claims that traumatism sometimes produces progressive paresis, which assumes the paralytic dementia type. Marcé[3] says, concerning the psychoses produced by traumatism: "In the greater number of these patients the mental disease assumes an illy-defined form, offering irregular alternations of stupor, agitation, and imperfect lucidity, without systematized delirious ideas, but recovery is never complete, and the patient becomes progressively demented." Calmeil[4] and Laségue[5] cite cases of patients being seized by epilepsy at puberty, after having sustained injuries to the skull in childhood, and becoming victims of progressive paresis at the age of 50.

Krafft Ebing[6] "classifies insanity from traumatism as it is: First, the direct consequence of an accident; second, manifested later, the prodromus of disordered motor and sensory

phenomena and change of character; third, preceded by a latent susceptibility (the result of the accident), which may be called an acquired predisposition, and which only requires an exciting cause to develop into actual insanity."

Crichton Brown[7] gives the following cases of psychoses preceded by traumatism:

PSYCHOSIS.	CASES.
Amentia	1
Mania, acute	1
" puerperal	1
" general	2
" recurrent	1
" *a potu*	3
Dementia	9
" with epilepsy	5
" senile	3
" with general paralysis	3
Melancholia, hypochondriacal	3

This table scarcely needs a comment, and it speaks very strongly as to the knowledge of clinical psychiatry, of any one, that they are capable of charging cranial injuries with producing *senile* dementia, *puerperal* mania, and mania *a potu*. Bucknill and Tuke[8] cite a case where a "fall on the back of the head" led to irritability, violence, and, finally, general paresis, and one case where a patient became emotional, irritable, and depressed, after a fall, and finally presented all the physical symptoms of progressive paresis, his memory remaining good. Schläger,[9] in a very valuable article on this subject, gives the following statistics and opinions: Of five hundred cases of insanity, he found forty-nine resulting from injuries to the skull. In twenty-one of these the injury was followed by immediate loss of consciousness, in sixteen by simple mental confusion and wandering of the thoughts, in sixteen by dull pain in the head. In nineteen cases the disease, insanity, com-

menced within one year after the accident; the other cases after an interval of from four to ten years after the accident. Generally the patients manifested from the time of the injury a tendency to cerebral congestion, after the ingestion of even a small amount of spirits, or, mental excitement. In several cases ocular hyperæsthesia and even amblyopia made its appearance. In fifteen cases there appeared, shortly before and during the existence of the cerebral disorder, scotomic dots, which exerted a deciding influence on the character of the delirium. The patient often experienced ringing and noises in the ears. In eighteen cases there was dulness of hearing; in three, abnormal subjective perceptions of smell, and changes in the pupils. Frequently the character and disposition changed. In twenty cases great irascibility and an angry, passionate manner, even to the most violent outbursts of temper, was remarked. Sometimes, but far less frequently, there occurred over-estimation of self, prodigality, restlessness, and disquietude. In fourteen cases there were attempts at suicide, and frequent loss of memory and confusion. The prognosis in all was unfavorable; seven became progressively paretic.

Esquirol[10] and Rush[11] both cite cases of mania produced by an injury. Azam's[12] article on the subject scarcely deserves notice. From the majority of these authorities, therefore, it would appear as if traumatism produced not only the form of insanity ascribed to it by Skae, but also other forms widely different from this.

My own cases, forty-five in number out of a gross total of twenty-two hundred cases of insanity, a smaller percentage than that of Schläger, range themselves as follows:

		NUMBER.
1.	Epileptic dementia, ...	10
2.	Epileptic mania ending in paresis, ...	12
3.	Mania chronic with depressing delusions, . .	8

4. Mania chronic with depressing delusions ending in progressive paresis, ... 10
5. Acute mania, ultimate history not known, . . 2
6. Acute mania ending in paresis, ... 2
7. Melancholia attonita, ... 1

The epileptic dements from traumatism did not vary any from the ordinary epileptic dement, and therefore scarcely need extended notice. As a rule, this class of patients had sustained the injury between the ages of ten and twenty-five. Those of the second class had usually sustained the injury between the ages of twenty and thirty-five, and of these varieties the following cases are a fair example.

CASE 1.—E. A., English, moderate drinker, common school education, was admitted to the asylum during the year 1873. Two years and a half previous had been struck on the head by a cake of ice, causing loss of consciousness for a time. A week after he had convulsions which recurred every twenty-four hours for one month and then ceased for three months, then returned at intervals of from one, two, to three months. The patient was at times violent and excitable, but on admission denies all knowledge of the periods of excitability that led to his arrest. He had a very vague aura preceding his convulsions and was slightly hesitant in speech. He continued in much the same condition for three months, being considered a case of epileptic mania passing into dementia. Eight months after this he had hallucinations which soon disappeared, he becoming alternately stupid and excited, and finally completely demented, remaining in this condition for eight months. He then began to exhibit delusions about making money by millions in the ice business, pilfered from his neighbors, and exhibited considerable motor and emotional disturbance. He soon exhibited all the usual mental and physical symptoms of progressive paresis, and died exhausted in the course of a year from several convulsions.

In this connection I may observe that the psychoses due to traumatism seem to be divisible into two great classes, those due to slight traumatism and those originating in traumatic injuries of a grave character. To the former class belong the cases of mania chronic with depressing delusions, while to the latter belong the other types of insanity.

CASE 2.—D. P., Irish, admitted to the New York City Asylum during 1873, was then in a condition of chronic mania with depressing delusions, and his friends gave the following history: In the spring of 1871 was struck on back of the head with a slung-shot during a street fight, after which the patient who had hitherto been good-humored became irascible, and at length had fully developed delusions of persecution which were well marked and systematized. He had hallucinations of hearing and marked insanity of manner. His delusions were built up on sundry slight circumstances and relatively logical. The patient had, on admission, a hard, dry, constrained manner, talked very suspiciously, recognized clearly that he had been committed to an asylum for the insane, but took this fact with relative calmness. He was induced, after some persuasion, to engage in some labor in the ward. The hallucinations were very vivid; the patient, however, regarded them as schemes of his enemies, and they caused him less annoyance than is usual with hallucinations. He was very careful of his dress and rather dignified in manner. He treated the physicians with relative politeness with the exception of the superintendent, who at one time acted dictatorially to him, and whom he in consequence regarded as one of his enemies. He died five years after admission, retaining to the last all his delusions.

CASE 3.—This patient was admitted in 1872; was then a clear case of chronic mania, with depressing delusions. The patient, previous to receiving a pistol-shot wound, of slight character, of the skull, was a cheerful, good-humored companion, but after recovery from this wound, became irritable, suspicious, and querulent. The patient remained about six months in the asylum, and was then taken out by his friends, but, becoming unmanageable, was returned early in 1873, having then well-marked delusions about his brother attempting to poison him, together with hallucinations about being denounced as an enemy of mankind. He was again taken out by his relatives, but returned in 1875, and was then a well-marked case of general paresis, of which he died in 1877.

These three cases are typical ones of certain phases of insanity, as produced by traumatism, coming under observation. As already remarked, slight traumatism seemed to produce different effects from grave traumatism, and these and other points connected with the question can best be shown in tabular form:

TABLE I.

	SLIGHT TRAUMATISM.	GRAVE TRAUMATISM.	TOTAL.
Epileptic dementia,	2	8	10
Epileptic mania, ending in progressive paresis,	4	8	12
Acute mania; ultimate history unknown,	2		2
Acute mania, ending in progressive paresis,	2		2
Melancholia attonita,	1		1
Chronic mania, with depressing delusions,	6	2	8
Chronic mania, ending in progressive paresis,	8	2	10
	25	20	45

From this table it would appear as if the majority of cases had resulted from slight traumatism.

TABLE II.

	HEREDITARY TAINT.		NO HEREDITARY TAINT.		
	Slight Traumatism.	Grave Traumatism.	Slight Traumatism.	Grave Traumatism.	TOTAL.
Epileptic dementia,	1	6	1	2	10
Epileptic mania, ending in progressive paresis,	3	6	1	2	12
Acute mania; ultimate history unknown,	2				2
Acute mania; ending in progressive paresis,	1		1		2
Melancholia attonita,	1				1
Chronic mania of depressing type,	2	2	4		8
Chronic mania, ending in progressive paresis,	2	2	6		10
	12	16	13	4	45

TABLE III.

Ages—	20–25,		25–40,		40–50,		
	SLIGHT.	GRAVE.	SLIGHT.	GRAVE.	SLIGHT.	GRAVE.	TOTAL.
Epileptic dementia,	2	7		1			10
Epileptic mania, ending in progressive paresis,	2	1	2	6		1	12
Acute mania; ultimate history unknown,			1		1		2
Acute mania, ending in progressive paresis,			1		1		2
Melancholia attonita,	1						1
Mania chronic, with depressing delusions,	2	1	4			1	8
Mania chronic, ending in paresis,	2	1	3	1	2	1	10
Total,	9	10	11	8	4	3	45

From these cases it would seem to me that the following conclusions follow:

First, that traumatism produces certain psychoses.

Second, that the majority of these are unaccompanied by epilepsy.

Third, that the majority have a tendency to end in progressive paresis.

Fourth, that a large proportion are accompanied by depressing delusions.

Fifth, that the majority of these latter do not exhibit any hereditary taint.

Sixth, that, with certain modifications, Krafft-Ebing's conclusions respecting the traumatic psychoses are correct.

Seventh, that injuries received before the age of forty are probably of more effect in producing insanity than those received subsequently.

Eighth, that slight injuries, from the insidious nature of the changes they set up, are as much to be dreaded, if not more, than the grave injuries.

Ninth, that traumatic causes did not have as much influ-

ence in the production of insanity as intimated by Schläger, he finding that over eight per cent. of the cases were caused by traumatism, while at the New York City Asylum for the Insane but two per cent. were so caused.

Tenth, that certain cases of insanity caused by traumatism have well-marked systematized delusions.

Eleventh, that in all cases of insanity caused by traumatism a guarded prognosis should be given.

VII. PSYCHOSES PRODUCED BY QUININE.

That quinine should exceptionally produce psychoses, will scarcely appear surprising when its tendency to produce cerebral hyperæmia is recollected. I am unacquainted with any literature on the subject, and, therefore, report only the cases which have come under my observation.

CASE 1.—T. P., American, single; grandfather, uncle, and brother died insane. Patient had, however, been in very good health up to about three months before admission, which occurred during the year 1874, when he was attacked by headache, for which, on the supposition of its being malarial, three grains of quinine were prescribed three times a day; after taking three doses of this the patient was seized by a violent attack of acute mania, with marked hallucinations of hearing of a depressing type, and considerable dimness of vision. These phenomena persisted for three months as the quinine was continued, and the patient treated with morphia subcutaneously. On admission to the asylum, which was at length rendered necessary, the patient was in the condition already described, and was placed under chloral and hyoscyamus as a hypnotic, and conium to quiet motor excitement. Under this treatment the patient was in fit condition to be discharged within six weeks after admission. He manifested, a day previous to discharge, some slight evidences of malaria, whereupon quinine was administered, which had the effect of bringing on a fresh attack of acute mania, with the same symptoms as previously. The quinine was stopped, and the same treatment as before resorted to, when the symptoms of acute mania disappeared. The patient was discharged, fully recovered, four months after admission, but returned within a year in the same mental condition,

under precisely the same circumstances, to recover and to have a relapse under much the same circumstances as on the first occasion.

CASE 2.—P. J., Irish, æt. 30, married, brother insane, sister epileptic, uncle afflicted with shaking palsy, was admitted to the New York City Asylum in a condition of extreme dementia, being able to utter but few words, and being very neglectful about himself and his surroundings. He had been in relatively good health up to about three weeks prior to admission, when he was attacked by a slight chill, for which he was given ten grains of quinine; in three hours after he sank into the condition in which he was on admission, but from which he recovered after three months' treatment in the asylum. In 1875 he was admitted in precisely the same mental condition from the same cause; was treated much the same, and had apparently fully recovered, when, manifesting some evidences of malarial infection, an assistant physician, who was ignorant of his history, ordered him five grains of quinine, which had the effect of producing a relapse, the patient returning to much the same mental condition as he was on admission. He, however, at length fully recovered.

These cases are the only ones I have seen in an asylum experience covering over two thousand cases, and although exceedingly few in number, are, I think, of sufficient value to serve as the basis of the following conclusions:

First, that in hereditarily predisposed individuals, quinine may give rise to psychoses.

Second, that these psychoses may present themselves in two groups: one of which is a form of acute mania, with aural hallucinations, probably not entirely independent of the physiological effects of the quinine; and the other, that of extreme dementia.

Third, that quinine can exert this ætiological influence but rarely.

Fourth, that a favorable prognosis, like the prognosis in regard to the individual attacks of all acute cases of insanity occurring in hereditarily predisposed individuals, can be given.

VIII.—PSYCHOSES PRODUCED BY LEAD.

While lead appears to be a not infrequent cause of general neuroses, opinions vary widely as to the extent of its etiological power in the production of insanity. Exact figures are wanting, however, though details of well-reported cases are by no means uncommon. Among the earliest to describe cases of this kind was Tanquerel des Planches,[13] whose description is one fully covering many points of value even now. He found that lead produced both an acute and a chronic form of insanity, the acute form being a species of melancholic frenzy with great incoherence. Lange,[14] Closs,[15] and Boettger[16] describe cases of a similar type. Moreau[17] (de Tours), Bottentuit,[18] and Guislain[19] narrate cases of melancholia attonita due to this cause. Leisdesdorf,[20] Popp,[21] Brochin,[22] and Hirt[23] report cases of what they call mania transitoria due to this cause, the mania having a decidedly melancholic type. Bartens,[24] in a recent interesting article, deals with this subject very fully, and finds that the psychoses produced by lead are both of a chronic and acute variety; that the acute form is a species of mania transitoria of short duration, depressing type, great incoherence, and very vivid hallucinations of sight and hearing. Lead poisoning has, according to Falke,[25] produced very similar phenomena in cattle. In some cases melancholia attonita is present. The chronic type presents hallucinations of taste, touch, sight, and hearing; the patients are suspicious, and have delusions of persecution. Some present the physical phenomena of progressive paresis. The prognosis in the acute type, according to Bartens, is by no means unfavorable; two-thirds of his cases recovered. Paralytic and choreic complications are not rare, and the maniacal furor is at times not unlikely to lead to death from exhaustion. The prognosis of the chronic type, as

regards recovery, is, of course, unfavorable. The great tendency of these latter cases to the development of apoplectiform attacks renders the prognosis, as regards life, a very grave one.

Maccabe[26] reports a case of what he calls monomania with depressing delusions and hallucinations, clearly traceable to the use of lead. I have, in all, seen thirty cases of insanity due to lead poisoning, about one and a half per cent. of all cases of insanity coming under observation. There were in the great majority of these cases a strong hereditary taint. The cases presented themselves in three great groups, one, in which there was a marked melancholic furor of relatively short duration, subsiding under antisaturnine treatment, or on the appearance of wrist-drop or lead colic. Of this type, the following three cases may serve as examples:

CASE I.—J. P., æt. 30, Canadian, painter. Mother died during an epileptic attack, as also did the maternal grandfather. The patient, who is very regular in habits, was in good health up to about a week before admission, when, after working at his trade for about a month, he was noticed to become delirious, after having complained for some days previously of his head. On admission the patient had very vivid hallucinations of sight and hearing; complained that the Fenians, clad in deep green, were in search of him to shoot him, and that he both saw the men and heard their guns go off. He was much emaciated, and had not slept during the week prior to his admission. On examination, a deep blue line was found on his gums. He was placed, in consequence, on iodide of potassium, chloral, and conium. He slept very well during the first quarter of the night, but was noisy and boisterous during the remainder. It was ascertained on the morning of the following day, that the patient complained of his food being poisoned. He was given sulphuric acid lemonade, as he complained of great thirst. This treatment was continued for three days, when the patient grew somewhat quieter, his hallucinations becoming less vivid, and his agitation, which had been very great, markedly diminishing. Two weeks after admission, the patient was discharged, fully recovered.

This case presents many analogies to the acute form described by Bartens. Against the term transitory mania, as used by him, Falcke, and others, there are strong and valid objections. The type of insanity is not a mania but a melancholia with frenzy; the disease lasts longer than any case of transitory mania, and in no respect presents the psychical features of that disease. The treatment adopted in this case was purely symptomatic, the saturnism being dealt with as a complication and treated specially. The second case is as follows:

T. P. Irish, æt. 29, was brought to the asylum in a condition of melancholia with frenzy, rushing excitedly around the room with his eyes covered by his hands and shouting "mercy! mercy!" The patient was much run down physically, but at the first examination no details concerning his history could be gleaned from him. He was sent to a room and ordered cannabis Indica, conium, and laudanum, which seemed to have but little effect. He would not eat any thing next day, and while feeding him by force a blue line was noticed on his gums. Acting on this therapeutic hint iodide of potassium in large doses was given him during the following day; he slept quietly during the early part of that night, but grew very noisy toward morning, the previous treatment being continued. This treatment was kept up for about a week, when, the patient having fully regained his strength and resting well, the sedative mixture was stopped, the iodide being kept up, and an occasional enemad given. The patient was discharged, one month after admission, fully recovered, and gave, on leaving the asylum, the following history: His family history was very unfavorable. The father died of apoplexy, a paternal uncle was an epileptic, and two sisters are insane. The patient himself, who is a painter by trade, was in relatively good health until about three weeks before admission, when he was taken by frequent attacks of vertigo, at one time amounting to almost complete unconsciousness. During one of these attacks he stepped down from the ladder on which he was standing while painting, and recollected no more until he found himself in the asylum. He had remained in good health for about two years after his discharge from the asylum, at which time he passed from under observation.

The third case differs in some respects from the other two.

J. R., æt. 31, American; father an inmate of the asylum, mother had died an inmate of the female asylum. The patient has been in very good health up to six weeks before admission, at which time he began to feel "dizzy," staggered at times without apparent cause, and complained of a blur before his eyes. The patient made bird-cages, and lived in a close-confined room in the rear of his shop which, itself, is not well ventilated. He had been working hard for some time previous to admission, scarcely stopping for his meals. On admission the patient was markedly agitated, complained of being played upon from a hose filled with hot water, closed his eyes and stopped his ears, declaring what he saw and heard were too frightful for utterance. He was treated for three weeks with sedatives, in which opium predominated, without apparent effect. One day he was found in a condition of slight confusion, his hallucinations and agitation having disappeared, but both wrists presented the characteristic phenomena of lead-poisoning. His gums showed the pathognomonic blue lines. The patient on being placed under iodide of potassium and the usual anti-saturnine treatment made a rapid recovery.

This case is not without a parallel among those recorded by Bartens and others, for he cites, as a common phenomenon, the disappearance or amelioration of the psychic symptoms on the full evolution of "drop-wrist" and other physical symptoms of lead poisoning. The suspicion of lead poisoning would readily arise in the first two cases on account of the patient's occupation, but not so readily in the third. The second group in which lead exerted an etiological influence is well exemplified by the following cases.

CASE 1.—R. McG., æt. 29, painter; strong hereditary taint, intemperate; was admitted to the asylum once before about a year previous; then in a condition of melancholia attonita, coming on after an attack of lead colic, and recovering under anti-saturnine treatment. He has had another attack of lead colic, subsequent to which the following psychical phenomena, now present, were observed. He has a markedly suspicious manner, unsystematized delusions of persecution, very vivid hallucinations of sight, taste,

touch, and hearing. These phenomena after three months of anti-saturnine treatment disappeared, and he engaged again in his trade; was attacked once more by same symptoms, became and remained an inmate of the asylum for two years, being then taken out by his friends in much the same condition as he was upon his third admission. He died six months after discharge, from apoplexy, having sunk into slight dementia for three months previous to this.

CASE 2.—Jno. R., painter, æt. 30, unmarried, intemperate. Father died of apoplexy, two brothers and a paternal cousin are insane. The patient was in very good health up to about three weeks before admission, when he began to complain of being followed about, when returning home from work, by men having evil designs on him. He was restless and uneasy at night, and frequently searched his rooms to ascertain if any person were hidden in them. This patient on admission had a hard suspicious manner, refused to enter into a lengthy conversation, and had evidently hallucination of hearing. On examination a blue line was discovered on his gum, whereupon he was placed under treatment for lead poisoning. He recovered after two months' treatment, and was discharged. Six months after he was again admitted, was much in the same mental condition as on his first admission, except that he now displayed unsystematized delusions of persecution. He had had an attack of wrist-drop some weeks previous to the present admission, but, disregarding these ominous symptoms, continued to work at his trade, but began at length to display such active symptoms of insanity, that his friends regarded asylum treatment as necessary. He was again placed under anti-saturnine treatment, but although the vividness of his hallucinations grew less, he still retained his insanity of manner, and was somewhat feeble in memory. Three months after admission, epileptoid attacks developed themselves, and in one of these the patient died.

There was, it is obvious, in these two cases, a progressive mental enfeeblement from the time of the second attack. The cases belonged to a large group, which hovers between monomania and dementia, with unsystematized delusions of persecution. The third group is well exemplified in the following cases:

CASE 1.—J. G., German, æt 41, painter; was admitted to the asylum with the history of having suffered at various times from attacks of insanity on several occasions, all of which preceded by one week an attack of lead colic, and were evidently referable to the same cause. Four months before his admission he was attacked by lead colic, which was preceded as before by insanity. This, however, did not subside as before on recovery from the lead colic, but continued, and the patient was transferred to the asylum. On admission he presented the following symptoms: His pupils were markedly unequal, both responding feebly to light. The facial folds were also unequal, and his tongue was tremulous. His speech was hesitant; he was markedly emotional, and he had delusions, both equally unsystematized, of grandeur and persecution. These symptoms improved for a time under ergot and iodide of potassium, but the patient's mental condition was that of intellectual enfeeblement. He had from time to time rather stupid delusions about poisoning. After about two years' treatment, the patient died from a paretic convulsion.

The next case has been elsewhere quoted[27] in illustration, however, of something other than its etiology.

CASE 2.—J. H., Scotch, æt. 36. Three months before admission, early in 1876, had lead-colic, succeeded by an attack of drop-wrist, which in turn was followed by hemiplegia and aphasia. The patient recovered from this under anti-saturnine treatment, but slight spots of his skin began to change color, followed by similar changes in his hair. On admission the patient presented the usual mental and physical symptoms of progressive paresis. Four months after admission he complained of band-like sensations about the fifth lumbar vertebræ, with electric-like pains down his thighs. He was at length confined to bed, dying within three months from a paretic convulsion.

Before contrasting these results with those obtained by Bartens and others, it would be well to enquire what peculiar forms of insanity lead has given rise to. Of these thirty cases eight were cases of melancholia, of greater or lesser duration; three, cases of acute mania, of short duration; five were cases of the second group; nine were cases of ter-

minal dementia; and five were cases of progressive paresis. In contrast with these results it may be said that the cases reported by Bartens have been principally mania transitoria, at he puts it, properly melancholia with frenzy, and a form of what he calls insanity with apathy, really melancholia attonita. The chronic types given by him were principally dementia. While it cannot be said that these cases denote that lead produces peculiar psychoses, it certainly gives a depressing tinge to any psychoses it produces. Like Bartens I have found that the acute psychoses produced by lead have a favorable prognosis; all of my cases recovered, but the chronic forms all died insane, or still continued to be insane long after my leaving the asylum. From these cases I feel warranted in concluding:

First, that lead poisoning produces certain psychical manifestations.

Second, that these manifestations may be of an acute or chronic type.

Third, that in any case the psychosis always preserves an element of depression.

Fourth, that the acute forms usually resemble melancholia with frenzy.

Fifth, that the chronic forms vary from a condition resembling monomania, but with a strong element of dementia, to progressive paresis.

Sixth, that the prognosis in the acute types is favorable.

Seventh, that anti-saturnine remedies are of great value in treatment.

Eighth, that the prognosis of the chronic types is, as might be expected, bad.

Ninth, that heredity, as in all other psychoses, is an important element in the production of these.

IX.—STEALING AS A PREMONITORY SYMPTOM OF PROGRESSIVE PARESIS.

Lélut,[28] Baillarger,[29] Parot,[30] Billod,[31] Brierre de Boismont,[32] A. Sauze,[33] Maudsley,[34] Burman,[35] Fabre,[36] Darde,[37] Mickle,[38] Voisin,[39] and others, have reported various cases in which paretics have committed thefts and other violations of morality. My experience in this matter has been, by no means, an unusual one. I have observed many cases in which phenomena of this kind were the first obvious evidence of the patient's insanity, but which was not recognized until the patient had been tried and condemned to the penitentiary. The following case fully illustrates this:

CASE 1.—R. C., Irish, stone-mason, had been an honest, hard-working man up to a month prior to admission, when he deliberately entered a variety store, and in plain view of every one took four shirts. Despite the peculiar stupid character of the act the man was tried and, as the store had been much victimized by shoplifting before his attempt, received a sentence of six months in the penitentiary. About a week after his arrival there he was noticed to be very uncleanly in habits, and was several times punished without effect, when it was suggested that the patient might be insane. On an examination of his mental condition being made he was found to have very expansive delusions. The patient was in consequence transferred to the asylum, and on admission presented the usual symptoms, mental and physical, of progressive paresis, from which disease he died a year and a half later.

Certainly it was a great injustice that condemned this man to the penitentiary and to the punishment inflicted on him there. It strongly hints at the propriety of submitting every case of theft, where the exact motive is inexplicable, to medical examination. The psychological basis of these thefts is easily explained. The patient claiming to be wealthy regards himself as taking things on credit to be subsequently paid for.

This propensity for stealing of the paretics led me to watch for a year a case of monomania in whom it appeared suddenly, and who, a year after, developed marked symptoms of paresis. These cases, clear as they may be at times, should lead to a little caution in the condemnation of all criminals whose crimes are a little inexplicable on the grounds of stupidity.

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